National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from Abertawe Bro Morgannwg University Health Board – OS 16

Abertawe Bro Morgannwg University Health Board [ABMU HB]: Response to the National Assembly for Wales' Health and Social Care Committee [HSCC] Short Inquiry into Orthodontic Services in Wales.

April 2014

1. Background

ABMU Health Board provides orthodontic services from both within the hospital and community based specialist practices, the latter including three dentists with a specialist interest [DwSIs]. The specialist and DwSI services are delivered through Primary Dental Service [PDS] agreements. Details of the contracted activity within ABMU are set out in the table below:

Location	Provider	Contract Vol (UOAs)	Contract Value (£)
Swansea	Specialist practices	32,836	2,043,611
	DwSI	2064	124,522
Neath Port Talbot	DwSI	2045	127,620
Bridgend	Specialist practice	7,823	490,809

The total value of the PDS contracts is £2,786,563 and accounts for 10% of the total GDS budget allocation in ABMU HB. Nationally, it is understood that orthodontic expenditure accounts for around 40% of the spending on NHS dental services for children.

It is important to note that activity undertaken within specialist practices in ABMU HB will be inclusive of referrals for residents of Hywel Dda Health Board and that the secondary care service provision is wholly inclusive of Hywel Dda residents.

The South West Wales Orthodontic Managed Clinical Network which reports to Hywel Dda and ABMU Health Boards has submitted evidence directly to the HSCC. It is understood submission from the network represents the views of the majority but not all of the network members and has been submitted with the *caveat* that it is primarily a service provider's perspective.

This submission from ABMU Health Board reflects its broader role and responsibilities in respect to integrated planning of services based on the wider dental public health requirements of the population and in line with the Board's Local Oral Health Plan [LOHP]that was submitted to Welsh Government in December 2014.

2. Question

The impact of the dental contract on the provision of orthodontic care and whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money?

2.1. Response

In an environment of 'prudent healthcare' and care based on best evidence then the key factors to consider when attempting to respond to this question are (i) the health gain associated with orthodontic treatment, (ii) the true need of the population and (iii) the potential for service modernisation. Without this information it is impossible to assess whether orthodontic care is adequate, affordable or provides value for money.

i. Health Gain

The health gain associated with the majority of orthodontic treatment has become less clear in recent years. However, it is acknowledged within the Health Board that not all orthodontists support the emerging views.

The major dental public health issue affecting the population is tooth decay (caries) and gum disease (specifically periodontal disease i.e. gum disease which may risk tooth loss in some individuals). The major risk factors for these diseases are primarily poor oral hygiene and diet (the basis for the preventive 'Designed to Smile' programme) with chileredn from lower socio-economic groups particularly vulnerable. Evidence suggests that if these factors are improved then the risk of gum disease or tooth decay reduces significantly even in the presence of irregular teeth or an 'atypical' bite. Paradoxically, children who are at risk of gum disease and tooth decay are ,correctly,refused access to orthodontic treatment since placement of braces in such an environment increases the risk of further disease.

It is understood that evidence would also suggest that orthodontics may not have significant long-term beneficial effect on the majority of jaw or bite irregularities. However orthodontics may improve an individual's self esteem by improving the aesthetics of their teeth. However, it is unclear how best to identify which patient groups benefit from an intervention for aesthetic reasons. There are obvious exceptions where the benefits of orthodontic treatment is unquestionable, egb for patients with significant abnormalities such as cleft palate. These most severe discrepancies require an orthodontic intervention together with surgical correction of the facial bones or defects (orthognathic surgery). The number of patients with this degree of irregularity is however limited but require highly specialized multidisciplinary teams.

ii. Need

Historically, the orthodontic need has been based on the Index of Orthodontic Treatment Need [IOTN]. However, it is understood that the validity and robustness of this method of assessment has now been questioned. For example, as a consequence of the IOTN being applied, in ABMU HB there are 1,067 (as of December 2013) patients aged 11 years or younger awaiting orthodontic assessment in specialist practices (approximately 20% of patients waiting for assessment). The Health Board has found it difficult to understand this demand based on the evidence available especially considering the pressure it places on resources and at a time where the

Board strives to embrace and implement the concept of 'prudent health care' in all the services it provides and commissions.

iii. Service Modernisation

Welsh Government's 2010 review of orthodontics led by Professor Stephen Richmond recognised that the normative need of 12 year olds requiring orthodontic treatment should and could be met within the existing resource that was committed at that time by Health Boards across Wales through existing PDS agreements. Professor Richmond's report highlighted areas of the service delivery model which, if changed, would lead to efficiencies in the service without negatively affecting the quality of care. Although there have been developments, such as the establishment of MCNs, it is disappointing to report that, to date, there has been little change in the service model.

For example, in ABMU LHB there has been little expansion or development of DwSI or orthodontic therapists and no contracts put in place which reflect and encourage economies of scale. In fact, contrary to the conclusions of Welsh Government's Orthodontic Review (2010) some colleagues within the orthodontic specialty have advised since that orthodontic therapists will not provide any opportunity to improve the cost effectiveness of the service. This is in direct conflict to the information provided to justify the development of this group of individuals within the UK and evidence provided to HSCC in 2010-11. This advice would also appear to undermine the strategic basis for the expansion of dental care professionals (DCPs) more widely and their roles within the UK. Some orthodontic specialists have also expressed concern over the model for Dentists with Specialist Interests in orthodontics which, again, was seen as a development to aid the implementation of a more efficient service in Welsh Government's Review (2010) and HSCC's recommendations in 2011.

Without workforce modernisation and orthodontic specialists' active support and involvement in training and employment it is unlikely that DwSI in orthodontics or the wider use of orthodontic therapists in Wales will develop. In addition, as recommended in the 2010 Welsh Government review, there should be clear incentives through the contract process to facilitate service modernisation. This should allow more effective planning and management of orthodontic services and removal of potential perverse incentives. Regrettably there appears to have been little progress on this to date.

2.2. Question 1:Conclusion

Health Boards need to balance the demand for 'routine' dentistry for the population at large with the provision of more specialised dental services. In the current climate of 'prudent' healthcare, serious consideration needs to be undertaken to balance the demand currently anticipated by orthodontic service providers with the Health Boards' ability to deliver against actual patient need and health gain.

It is considered that until the actual health need of the population and the gain associated with the majority of orthodontic treatment is independently assessed, and robust criteria applied, it is impossible to state with certainty whether the current

spending on orthodontics is justified or sustainable. However, based on the current service models and criteria to assess need it is considered that additional investment in orthodontic services is not affordable or sustainable particularly as the there appears currently questionable evidence of value for money. Significant changes to improve the efficiency and effectiveness of the service would be required before further investment could be justified.

To resolve these issues it would probably be appropriate for the NHS to provide a definitive position on actual orthodontic need of the population, the health gain associated with active intervention and models for a modern service based on an independent evaluation of robust scientific information. In the meantime an increased allocation of resources to orthodontics from the GDS budget would divert monies from the most vulnerable, needy and at risk and would conflict with the broader needs of an ageing and more frail society. Perversely it would also redirect resources from the most at risk children to those of low risk of dental disease. This would be difficult to justify and would not be consistent with the key objectives set out in the Health Board's Local Oral Health Plan.

3. Question

Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales

3.1. Response

It is understood that there is variation in access to orthodontic services across Wales as well as differing access criteria for secondary care. This is often attributed to local circumstances e.g. number of specialist practitioners in the locality and variation in 'need' of local populations. A number of orthodontists work in both specialist and hospital based practice.

A centralised referral management system based on clear objective nationally described and agreed criteria for referral and access into specialist and hospital services would aid consistency across Wales and support planning by Health Boards. This should involve clarity as to where services should be delivered to improve access rather than simply reflect historical practice. Furthermore, as discussed previously, true 'need' requires clear definition and differentiation from 'demand'.

There has been a suggestion that prioritisation of patients accepted for NHS care should be introduced to improve access. If this is considered then it should not result in overall longer waiting times since it potentially diverts those in low priority groups who can afford to pay into the private sector and disadvantages poorer socio-economic groups.

It is understood that there is significant variation in the number of orthognathic cases treated across Wales. However national databases have recently been established by the specialist societies and NHS England. The NHS in Wales may wish to look at how best these could be used to inform Health Boards in planning and managing these services in Wales.

4. Question

Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector?

4.1. Response

Welsh Government has historically given a high priority to orthodontic services which has been reflected in resource allocation. This may be a consequence of idiosyncrasies associated with the change to the new dental contract in 2006, the pressure that is often placed on Health Boards where there are large waiting lists associated with the provision of paediatric services and a failure to differentiate between 'demand' and true 'need'.

Arrangements for monitoring standards of delivery and outcomes of care are hampered by a number of factors. For example, orthodontic payment is not linked to completion of treatment or robust quality of outcome standards or data. This causes problems for Health Boards as they attempt to manage services and budgets as well as removing a key incentive to practitioners. It is strongly recommended that these issues are considered as part of any new contractual discussions to ensure that there is an incentive for contractors to complete treatments and better enable Health Boards to manage the quality and outcome of services.

It is also considered that there is also a strong case, to aid monitoring of access, delivery, expenditure and outcomes, to separate primary care orthodontic budgets from the wider GDS budget and ensure that orthodontic services are managed within this financial envelope.

With a population of approximately 3,000,000, Welsh Government may also wish to consider the benefits of developing national standards for planning, and monitoring orthodontic services.

5. Conclusion

In trying to achieve a balanced approach to dental service delivery ABMU Health Board is seeking within its LOHP to consider service developments that will benefit the population as a whole rather than considering specific patient groups, access to primary general dental services being a key consideration. To achieve the balance of service provision required there must be positive and balanced engagement from all stakeholders and planning based on the best evidence available true 'need' not 'demand' and consideration to the most effective and efficient use of dental resources, including workforce, for the population. This may be best achieved by developing national guidance based on robust and independent evaluation of the best scientific evidence available.

There is also a need for all stakeholders, including professionals, to recognise the wider health needs of the population, the concept of 'prudent care' particularly within the financial climate that now exists, along with the need to deliver more specialised dental services within the primary and community setting for the general population. The National and Local Oral Health Plans have laid excellent foundations in this regard and it is crucial that the broad dental health agenda reflected therein is pursued consistently.